LITTLE HOOVER COMMISSION
STUDY OF CHILDREN'S MENTAL HEALTH POLICY

TESTIMONY OF
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Across the nation, state and local governments are implementing new approaches to policy, financing, and service delivery for children with mental health needs and their families. This increased focus on children with emotional and behavior problems reflects frustration that traditional approaches have been inadequate to meeting the challenges these children and their families present.

Data on the prevalence, severity and complexity of problems suggest that more children than ever before are in need of mental health services. Data also suggests that many troubled children are involved with multiple agencies – schools, child welfare protective services, juvenile justice, mental health, Head Start and child care centers. The complexity of children's needs requires comprehensive and coordinated approaches if interventions are to be successful.

Unfortunately, interventions often do not begin until children's problems are so serious that large expenditures of public resources are necessary. And when interventions do happen, studies indicate that most children get an inadequate level of services, services that are too restrictive for their needs (like hospital and residential care), or no services at all. One reason for this is that when services are offered, what is provided often depends on the agency door through which the child enters and, therefore, what types of services that agency has to offer. Another reason is that often there is little cooperation and coordination of efforts across agencies despite the involvement of these children in multiple agency systems. The effect is to further increase the likelihood of fragmentation, cost, and inappropriateness of services provided.

Yet the public will is strong to impact on these problems. Legislators, executive branch administrators, judges, community agency directors, and advocates all want the service system to work well for families. They want children protected from harm, ready to learn when they enter school, emotionally healthy, and not to pose risks to public safety. I cannot count the numbers of times that I have heard judges say, "I am ordering this youth into residential care because I am so frustrated that the agencies can't seem to do anything about him." Legislators, agency administrators and advocates have worked hard to address these frustrations by passing legislation, establishing policy directions, creating numerous funding streams aimed at addressing specific issues, and supporting public and private agencies as they try to meet the needs of families. They want the service system to work effectively on behalf of troubled children and their families.

California in many ways has been a leader nationally in passing legislation, appropriating funds, and building local cross-agency community service systems that address these issues in creative ways. California has long had system of care legislation. Reforms in the financing structure for services have provided incentives for mental health agencies to divert children from state psychiatric hospitals. Several California communities have, or in the past have received, federal Center for Mental Health Services grants to develop creative and cross agency community approaches to service delivery for children with serious emotional and behavior problems. Despite these efforts, much still needs to be done to reach the goal of having service systems across the state that work effectively on behalf of troubled children and their families.

GOALS FOR SERVICE SYSTEM IMPROVEMENTS

Improving outcomes for children with mental health problems and their families requires reforms not only in state and local mental health agencies, but across the major agencies that serve these children as well. It is in this context that I hope the Commission will address systems improvements.

The overall goal of systems improvements is for agencies and service providers to offer the highest quality of tailored services for troubled children and their families. Goals for reform at the state and local infrastructure levels, therefore, must focus on collaborative and cross agency systems level management structures, operational procedures, and funding mechanisms targeted to defined populations of children and their families. Goals at the service delivery level are cross agency collaborative structures for coordinated service planning and delivery, mechanisms to ensure individualized and comprehensive care, family focused intervention approaches, and the use of state-of-the-art service technologies to provide high quality care.

WHICH CHILDREN SHOULD MENTAL HEALTH PRIORITIZE WITH ITS SERVICES?

Nationally, many system level improvements have been directed toward children with serious emotional and behavior problems and their families. These groups are often specifically defined in legislation or policy (in about 30 states). The choice of this group is not surprising because these are the children and youth who cause the most problems in school and in their communities, who are most often involved with multiple agencies, whose needs are complex, and who are often placed into high cost services. Unfortunately, one limitation of many of the definitions used to delineate this group is the language used. The language often is heavy on mental health jargon. This results in other agencies being suspicious that “their kids” are being left out and that their agencies are being asked to “subsidize mental health.”

Most recently, there is an emerging movement across the country to direct system improvements toward young children ages birth to 5, 6, or 7 years of age and their families. These are children who are showing early emotional and behavior problems that will likely become more severe as they get older. These are children who are getting

kicked out of day care centers and who are entering school socially unprepared to learn. The movement is based on the belief that early intervention can avoid later more severe and costly interventions. Several states such as Vermont, Louisiana and Indiana are working in this area. Roxane Kaufmann, at the Georgetown National Technical Assistance Center in Washington, DC, and researcher and author Dr. Jane Knitzer, at the Columbia University National Center for Children in Poverty, are valuable resources for information about service approaches for this population of children.

BARRIERS TO PROVIDING HIGH QUALITY SERVICES

The barriers to providing the highest quality mental health services for troubled children and their families will probably sound very familiar to members of the Commission. They have been discussed and written about many times, dating back to the 1978 President's Commission on Mental Health, Jane Knitzer's book Unclaimed Children, and Stroul and Friedman's book A System of Care for Children and Youth with Severe Emotional Disturbances.

1. At the broadest policy level, state agencies are large, competitive and isolated from each other.

    a. Middle managers often buy-into and understand importance of collaborative policy, funding and service approaches, but frequently this is not supported by agency heads and cabinet secretaries. Middle managers provide consistency to the administration of their agencies and yet may not have the authority to embark on major innovative policy directions.
    b. Political changes bring new individuals to top positions in state and local government. These changes often result in policy focuses that are narrow to each agency and not population or issue focused across agencies. An agency head may want to improve education, but only by working with the schools or improve public safety, but only by seeking new funds for the juvenile justice system. State and local government policy tends not to support collaborative approaches to solving problems.
    c. It is very difficult to sustain even legislated collaborative efforts at the state and local levels as cabinet secretaries and agency heads change. Many states like Maine, Virginia, South Carolina, and Louisiana have Children's Cabinets or legislated state level interagency policy teams whose effectiveness seem to ebb and flow depending on the commitment of top officials.
    d. Mental health agencies have generally not developed partnerships with universities and community colleges to support workforce development. Therefore, many practitioners entering the field are trained in traditional service approaches and do not understand or even like the innovative directions being pursued by many local agencies. On-going in-service training that teaches new clinical and service technologies and collaborative approaches to services is rarely required for staff in all the local child-serving agencies.

2. State and local agencies see their missions as addressing defined efforts toward specific eligible groups of children. This has resulted in agencies that view the world in very categorical ways and that are extremely protective of their turf. Some effects of this are:

   a. Different eligibility requirements to receive services from each agency;
   b. Different eligibility requirements to receive different services provided within the same agency;
   c. Multiple categorical funding streams tied to additional client eligibility requirements;
   d. Federal and state mandates for agencies that often preclude attention to collaboration, even if collaboration would have greater impacts on accomplishing the mandates;
   e. Mission statements of agencies that are usually complimentary but tend to focus agency efforts inward;
   f. Competitiveness for scarce resources and the perception that, "If you get more dollars then I won't, and I lose;" and
   g. Overburdened staff who believe they have no time for collaborative activities. Staff are usually allied to a single agency culture rather than to the needs of children and families and, therefore, perceive their roles only within the confines of their agency. They realize but don't act upon the knowledge that these children and families cross all agency boundaries and have needs that can most effectively be met through collaboration.

3. Operationally at the state and local levels, there are barriers as well.

   a. There is often a lack of consensus across agencies on the directions to pursue to serve children who the agencies have in common. This is compounded by suspiciousness of the effectiveness of collaborative approaches to services, despite research evidence. Administrators are constantly asking, "Does this really justify the expenditure of my time with all the internal agency pressures I have?" Even when they are involved with collaborative, cross agency bodies, they often do not deal with policy and practice issues, but limit themselves to information sharing about what is going on in their agencies and how they do things.
   b. Most system of care legislation does not mandate tiered local administrative and service structures that are designed to do real cross agency management, funding and provision of services. Therefore, reform rarely reaches into the heart of each agency, changing policies that effect the operations of each agency and the use of staff time. Often there are not interagency team structures with sufficient authority to do comprehensive service planning, commit resources to the plan, and hold each agency accountable for providing the services promised.
   c. There is frequently strong agency protection of their funding and resistance to pooling or blending the funds into collaborative efforts.

Similarly, there is resistance to sharing scarce program resources, to open programs to serve broader populations, and to invest in jointly funded service expansions that can maximize scarce resources across agencies.

d. There is an unwillingness to put in place policy changes within agencies to support and require collaboration by their staff. The effectiveness of collaboration is often based on the commitment of individual staff.

e. Local agencies frequently lack respect for the families that they serve and therefore do not involve them as partners in planning services for them. Agencies are reluctant to involve parents in determining agency policy and evaluating the family friendliness and quality of the services provided.

f. Little attention has been paid to training staff on cultural sensitivity and culturally specific approaches to services. Agency staff or contracted service providers often do not reflect the races and cultures of the clients served. California, though, has made strong efforts in many local communities to become more culturally relevant with services and has models to use in assisting other communities.

4. At the service delivery level locally there are barriers as well, including:

a. Lack of a shared direction or clear expectations across agencies that managers provide their staff about working with staff from other agencies;

b. Poor quality or inadequate case management;

c. Lack of jointly sponsored training for direct care staff and cross agency teams that teaches how to employ new service approaches, how to do comprehensive service planning and delivery, and how to do "wraparound" or family centered service approaches;

d. Limited or no access to flexible dollars to pay for unique service needs of families; and

e. Few processes for direct care staff to raise policy and case specific issues to higher levels for resolution or assistance.

STRATEGIES FOR PROVIDING HIGH QUALITY SERVICES

There are many strategies that are being used across the nation for improving the quality of mental health services. Strategies focus at the broadest policy levels of state government, within and across state agencies, and at the local level within and across agencies. The following provides a summary of possibilities for Commission research and consideration.

At the broadest policy level in state government, there are a number of strategies that may be considered.

Legislation

California has long-standing system of care legislation. One approach being used by states to further structure collaborative service systems is to expand upon system of care

legislation to delineate tiered structures at the state and local levels to implement systems reform. An excellent example of such legislation is the Virginia Comprehensive Services Act. There are three key components of the Act. First, it mandates two-tiered structures at the state and local levels. The tiers help keep the reform process going even when there are political or administration changes that result in a lessening of commitment to participation in any one tier. Second, the Act requires the pooling of state dollars formally in categorical agency streams and the local match for these state dollars. When large amounts of money are being managed collaboratively, commitment to the process increases. Third, the Act clearly delineates the responsibilities of each tier. In practice, each agency at the state level takes the lead on implementing different responsibilities in order to accomplish tasks without adding new beauracracy.

System reform legislation, to be most effective in impacting on change, should feature several components, including:

1. The mission of the system of care;
2. Definition of populations to be served (focus on children with serious emotional and behavior problems, young children with early behavior problems, or both);
3. Administrative and direct service structures to be developed at the state and local levels to implement the mission. Responsibilities, authority, interrelationships, and required membership should clearly be defined for each structure;
4. Funds to be managed by the state and local administrative structures. This should be accompanied in policy by detail of which funding streams will be included, local match requirements, a formula for allocating resources to local administrative structures, and accountability procedures; and
5. Other existing legislated or mandated interagency processes that may be combined, at local discretion, under this new legislated structure. This will eliminate duplication and help simplify the service delivery system.

Executive Branch Leadership

The governors of several states such as Maine, Vermont, Louisiana, and South Carolina have by policy developed Children's Cabinets. The Cabinets are charged with exploring ways to improve policies, procedures, services, and funding to better serve children with emotional and behavior problems and their families. These efforts, to be effective, require the commitment of the governor's office to the process. Children's Cabinets frequently form working groups to investigate and make recommendations on policy and funding issues that can then be implemented across agencies.

Effective Children's Cabinets tackle some very difficult policy questions including:

1. Gaining internal consensus about the system reform directions that should be promoted and the populations of children to focus on;
2. How to engage in a consensus process statewide to gain input into and buy-in for a new system direction;

3. Mission of the new system of care and the responsibilities of each agency to promote it;
4. Principles of how services will be delivered and agreement to modify agency policies and local mandates in order to implement those principles;
5. Expectations and options for local implementation of the new directions; and
6. Realignment of current agency funding to support the directions.

Funding Realignment

Whether there is a policy or legislative approach to systems reform, the issues of funding must be clearly addressed. Without funding reform, there is little ongoing incentive for local agencies to develop a collaborative system of services. Additional funding reforms can be initiated by the state mental health agency to encourage quality clinical practice by community mental health centers.

1. There are several opportunities for realigning existing funding streams to support collaborative, non-categorical service provision. Information on strategies can be found in publications of the Georgetown University National Technical Assistance Center for Children's Mental Health and publications of Chris Koyanagi at the Judge David Bazelon Center. Both are located in Washington DC. Strategies include:

    a. Pooling discretionary service delivery funds located in the child-serving agencies. Examples include mental health hospital diversion and community incentive funds, mental health federal block grant funds, education funds used to pay for day and residential education services, and juvenile justice treatment program purchase of services funds;
    b. Blending and/or decategorizing agency funding streams. Examples include Title IV-B, Title IV-E room and board payments, and state legislated categorical funding to agencies for expenditure with specific eligibility groups served by those agencies;
    c. Identifying funding streams that will remain categorical, but will be managed through local collaborative structures. Examples include funds supporting foster care, early childhood health and education programs, juvenile justice diversion programs, mental health intermediate services, and mental health hospital and residential care facilities; and
    d. Adding local match funds required for accessing state categorical funds.

2. The state mental health agency can work in conjunction with the state Medicaid department to expand and realign the state plan to:

    a. Cover additional intermediate level services, including services delivered by paraprofessionals, and to stop covering residential treatment and hospital services;
    b. Establish a process for reimbursing clinical services that are provided by or in conjunction with non-mental public agencies;

c. Allow for and give incentives for the provision of clinical services in non-clinic settings like family homes and in schools; and
d. Covering case management through tiered rates that encourage the provision of intensive levels of services.

Information on these strategies can be found in publications by Chris Koyanagi at the Judge David Bazelon Center in Washington DC.

3. The state mental health agency can modify Medicaid managed behavioral health care contracts to require and reimburse intensive case management, and to support and reimburse for time spent in collaborative service planning and collaborative service delivery activities.

Additional State Mental Health Agency Strategies

1. The state mental health agency can take the lead on workforce development both within local mental health centers and across local child serving agencies toward implementing state of the art service technologies. This can be done through establishing relationships with universities and community colleges to:

   a. Better instruct students in new technologies needed in the field; and
   b. Provide on-going in-service training for current direct services staff on new approaches to service delivery.

   A good example of this approach is the collaboration developed in North Carolina between the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services and the University of North Carolina at Chapel Hill.

2. The state mental health agency can also accomplish work force development by taking the lead in setting up or contracting for its own training and technical assistance system. Successful programs take a three tiered approach that focus on competencies for community agency direct care staff, supervisors and managers. There are several good training curriculums that can be adapted for California use. These include the curriculum being developed for the state of Connecticut by Judith Meyers of the Child Health & Development Institute of Connecticut, the curriculum developed for New York by Cornell University, and curriculum developed by the Pennsylvania CASSP Training & Technical Assistance Institute.

3. Vigorously use performance contracts with community mental health centers to specify the array of services that will be provided and special provisions about how they will be provided in order to increase their accessibility, family friendliness, involvement of low-cost informal community resources, and cultural relevance.

4. The state mental health agency can also undertake a study of successful local system of care strategies used by federal Center for Mental Health local grant

sites nationally to provide high quality, family centered and collaborative services. The study could involve a task force comprised of state and local staff and parents. Strategies can then be selected and prioritized for California and incentive mechanisms put in place to encourage community adoption of the strategies. Many successful strategies are found in two series of documents: Systems of Care – Promising Practices in Children's Mental Heath and Annual Report to Congress – Comprehensive Community Mental Health Services for Children and Their Families Program. Both series are available from the Child, Adolescent and Family Branch of the federal Center for Mental Health Services.

5. The state mental health agency can also provide leadership and build strong working relationships with child mental health managers in the community mental health centers toward setting and implementing new service directions. Through the use of regularly scheduled regional meetings, as one strategy, program and funding information and opportunities can be shared, state directions for local system development can be communicated, successful local practices can be discussed, and peer to peer technical assistance can be developed.

6. The state mental health agency can take the lead with other public child serving agencies to develop a management information system that provides service and outcome data for local systems and allows managers at the state level to monitor local agency performance toward systems goals. The data can then be used to inform collaborative policy decisions at the state level and practice decisions locally.

At the local level, there are also a variety of strategies that can be pursued.

Local Community Mental Health Center Strategies

With or without state legislation and mandates, there are several strategies that community mental health centers can pursue to improve the quality of services. These include:

1. Promoting interagency collaboration. Initiate local collaborative bodies with responsibilities around system management and development, including:

    a. Setting a consensus direction for local systems development; revising agency policies and procedures to support this direction;
    b. Increasing the local array and flexibility of services;
    c. Increasing collaboration in new service development;
    d. Realigning existing services to be less categorical and to maximize the populations covered and reimbursement options;
    e. Developing collaborative service planning and service mechanisms for children and families; and
    f. Developing joint training on system of care principles and technologies.

2. Focus on the development of intermediate services within their centers and make current clinical services more flexible in hours and locations by:

    a. Making hours and locations of all clinical services family friendly and accessible;
    b. Out-stationing staff into other agencies;
    c. Particularly in the early intervention with young children arena, developing consultation and training for Head Start and day care providers to improve their capacities to work with children who present behavioral difficulties;
    d. Modifying contracts with private contract service providers to require flexible hours, locations of services, collaboration with other service providers, and the uses of new treatment technologies;
    e. Focusing on the development of intensive case management services and intermediate level community services;
    f. Training staff in comprehensive and collaborative service planning for children and families;
    g. Encouraging staff to hook families up with informal community resources; and
    h. Ensuring training and technical assistance for direct service providers, supervisors, and managers on instituting new system of care approaches.

3. Include parents on the boards of community mental health centers and in internal operations such as staff hiring, evaluation of service outcomes and consumer satisfaction, clinical policy and procedure development, and staff training.

This concludes my testimony. I hope that some of the ideas presented will be useful for the Little Hoover Commission as it strives to improve the quality of children's mental health services in California.